

2018 CAMPER HEALTH FORM

Camper's Name _____ Camp Attending _____

Medical Information

Operations or serious injuries _____

Penicillin or other drug reactions _____

Ever had a bee sting? _____ If yes, reaction _____

Food or other allergies _____ Special Diet _____

Medications currently being taken _____

(All prescription and over the counter medications, should be in original containers clearly marked with physicians instructions, and presented to the nurse at registration.)

In case of an emergency I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give permission to the physician selected by camp health personnel to secure proper treatment for my child including hospitalization and/or surgery. I give permission for the camp health personnel to administer non-prescription medications listed in the camp doctor's standing orders in the event of minor illness.

*Parent's Signature _____ Date _____

***Immunization Record: Please complete the attached Certificate of Immunization Form (including the signature of physician, nurse, or school health authority), provided by the Colorado Department of Public Health, or the Statement of Exemption to Immunization Law if you are opposed to immunizations. When completing the Certificate of Immunization Form, please provide the exact date (month/day/year) that the immunization was administered. Children will not be admitted to camp without one of these two forms fully completed. If submitting a copy of an official immunization record, camper's name must appear on the document.**

Physician's Section

I have examined this camper and found him/her to be in satisfactory condition, free from contagious disease, and capable of active participation at 10,000 ft. for one week in a regular camping program, except as follows: _____

*Physician's Signature _____ Date _____

Physician's Name _____

Address _____ City _____ State _____ Zip _____

Phone _____

Medical Insurance _____ Policy # _____ Phone _____

Assignment of benefits (signature of family member insured) _____

Doctor's name and phone # (if different from above) _____

Dentist's name and phone # _____

Camp Nurse's Signature _____

***Items with asterisk are required for camp admittance**